

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08518

CERTIFICATE OF DEATH

08508

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6801 WASHINGTON BOULEVARD 21227		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR B. CROOK		d. STREET ADDRESS 6801 WASHINGTON BOULEVARD	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month JUNE Day 3 Year 19 66	
9. AGE (In years lost birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James W. Crook		14. MOTHER'S MAIDEN NAME Mary E. Quinn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-07-6718	
17. INFORMANT MRS. MARGARET W. CROOK		Address 6801 WASHINGTON BLVD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 1419 IMMEDIATE CAUSE (a) Car of Tongue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute leukemia disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 10, 1960 to 2 June, 1966 , that (I) (we) last saw the deceased alive on 2 June 1966 , and that death occurred at 12:57 PM , from causes and on the date stated above.			
22a. SIGNATURE George E. Groleau M.D.		22b. DATE SIGNED 4 June 66	
22c. PHYSICIAN'S NAME (Type) GEORGE E. GROLEAU		22d. ADDRESS 5806 MAIN STREET-ELKRIDGE	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 6-6-66	
23c. NAME OF CEMETERY OR CREMATORY ST. AUGUSTINE'S CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		25a. REC'D BY REGISTRAR JUN 7 1966	
ADDRESS 4107 WILKENS AVENUE 21229		25b. REGISTRAR'S SIGNATURE Charles Judge	

08208

CRIMINAL RECORD

08208

NAME		LAST		FIRST		MIDDLE		SUFFIX	
DATE OF BIRTH		MONTH		DAY		YEAR			
SEX		MALE		FEMALE					
RACE		WHITE		BLACK		HISPANIC		OTHER	
EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY		OTHER	
OCCUPATION		FARMER		LABORER		CLERK		OTHER	
RESIDENCE		CITY		COUNTY		STATE		ZIP	
MARRIAGE		MARRIED		SINGLE		DIVORCED		WIDOWED	
CHILDREN		1		2		3		4	
PARENTS		FATHER		MOTHER					
Siblings		1		2		3		4	
Criminal Record		YES		NO					
Signature		[Signature]							
Date		1960		10		15			

RECEIVED
FBI - NEW YORK
OCT 15 1960
100-100000-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
08519					08509				
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b Ellicott City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ilchester Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Ilchester Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MARTHA Middle JANE Last FAY					4. DATE OF DEATH Month June Day 30 Year 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1876		9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard					14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Fay, Ilchester Road, Ellicott City, Md Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 7834 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 96 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-28, 1966 , to 6-30, 1966 , that (II) (we) last saw the deceased alive on 6-27, 1966 , and that death occurred at 8 P. M. from the causes and on the date stated above.									
22a. SIGNATURE Thomas F. Herbert, M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED 7-1-66	
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.								22d. ADDRESS 44 Church Rd., Ellicott City, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-5-1966		23c. NAME OF CEMETERY OR CREMATORY Rehobeth		23d. LOCATION (City, town or county) (State) Pricedale, Pa.			
24. FUNERAL DIRECTOR F.C. Higinbotham ADDRESS F.C. Higinbotham Funeral Home, Ellicott City, Md						25a. REC'D BY REGISTRAR JUL 5 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

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88510

Howard

Howard

Howard

Ellicott City

Ellicott City

Ellicott City

Ellicott City

June 22, 1962

PAID

JUNE

WATER

88

Sept. 1, 1960

X

Female White

Howard

Howard

Howard

Ellicott City, Md.

Howard

Howard

Ellicott City, Md.

Howard

7-7-1962

Howard

Ellicott City, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
08520					CERTIFICATE OF DEATH					08510				
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 3					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS Rt. 3 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) MARY EDITH FOX					4. DATE OF DEATH June 22, 1966					19				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Howard Co., Md				
13. FATHER'S NAME B. Franklin Keyes					14. MOTHER'S MAIDEN NAME Annie Sykes					12. CITIZEN OF WHAT COUNTRY?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. None					17. INFORMANT Charles C. Fox, Rt. 3, Ellicott City, Md Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO (b) Atherosclerotic cardio- DUE TO (c) vascular dis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH week				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from August 19, 1966 to June 22, 1966 that (I) last saw the deceased alive on June 22, 1966 , and that death occurred at 1 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Charles C. Fox					22b. DATE SIGNED 6/23/66					22c. PHYSICIAN'S NAME (Type) BALTIMORE NAT'L. PIKE & ST. JOHN'S LANE ELICOTT CITY, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 6-25-1966					23c. NAME OF CEMETERY OR CREMATORY St. Johns				
24. FUNERAL DIRECTOR F.C. Meginbotham, Ellicott City, Md					25a. REC'D BY REGISTRAR Charles Judge					25b. REGISTRAR'S SIGNATURE				
25c. LOCATION (City, town or county) Ellicott City, Md					25d. TELE. NO. 5-3420									

01589

01589

Howard

William

Howard

Elizabet City

Elizabet City

X

St. J.

St. J.

June 2, 1900

MARY EDITH FOX

St.

1881-1881

White

Female

Howard St. N.

At Home

Amesbury

Franklin Jones

Charles J. Fox, St. J. Elizabet City, N.

Home

No

Elizabet City, N.

St. J.

1881-1881

St. J. Elizabet City, N.

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VR A15 (4)
ISM 7/61

M
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08521

08511

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Guilford Road			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup d. STREET ADDRESS Guilford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MELVIN RUBIN KNISLEY First Middle Last			4. DATE OF DEATH JUNE 16 1966 Month Day Year		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900 August 23, 1900	9. AGE (In years and birthday) 65 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY general construction		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME David Rubin Knisley			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 17. INFORMANT Mary L. Knisley, Guilford Road, Jessup, Md Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 161X DUE TO 1. Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO metastatic carcinoma involving trachea Corcinoma larynx PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic carcinoma - lungs.					INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 gr.
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Corcinoma larynx			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/15, 1963 to 6/16, 1966, that (I) (we) last saw the deceased alive on 6/16, 1966, and that death occurred at M, from the causes and on the date stated above.					
22a. SIGNATURE Robert G. Chambers			22b. DATE SIGNED 6/16/66		
22c. PHYSICIAN'S NAME (Type) Robert G. Chambers			22d. ADDRESS 836 Park Ave. Bldg. 2nd		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 20, 1966	23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION (City, town or county) (State) Savage, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE De Witt Darnedson Laurel Md			25a. REC'D BY REGISTRAR DATE JUN 27 1966 Charles Judge		

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088574

CENTRAL CASE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

08522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08512

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Freetown Road, Box 34		d. STREET ADDRESS Freetown Road, Box 34	
3. NAME OF DECEASED (Type or print) First Middle Last Deborah Denice Kosh		4. DATE OF DEATH Month Day Year June 20 19 66	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1966
9. AGE (In years lost birthday) yrs. 4Mths		IF UNDER 1 YEAR Months Days Hours Min. 4Mths	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irvin Wilson		14. MOTHER'S MAIDEN NAME Delores Kosh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Delores Kosh		Address Same as item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3912 IMMEDIATE CAUSE (a) Otitis Media bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22. DATE SIGNED June 20, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/66	
23c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel		23d. LOCATION (City or Town) (County) (State) Highland, Md.	
24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md.		25a. SIGNED BY REGISTRAR JUN 23 1966 DATE	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

81/100

WILLIAM K. F. (1942) 100/100

05300



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08523

08513

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELLCOTT CITY				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 5713 Edmondson Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) TAYLOR MANOR HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First LOUIS Middle PHILIP Last KRAUS		4. DATE OF DEATH Month JUNE Day 20 Year 19 66			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-93		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 03 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE AGENT		10b. KIND OF BUSINESS OR INDUSTRY New York Life		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest Kraus				14. MOTHER'S MAIDEN NAME Bertha Mohlhenich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 216-28-5845		17. INFORMANT Mrs. Catherine E. Kraus same address as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Arteriosclerosis (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/12 , 19 66 to 6/20 , 19 66 that (I) (we) last saw the deceased alive on 6/20 , 19 66 and that death occurred at 3A M, from the causes and on the date stated above.							
22a. SIGNATURE Stephen Lee Magness M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS, M.D.				22d. ADDRESS TAYLOR MANOR HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/22/1966		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial Pk Cemetery		23d. LOCATION (City, town or county) (State) Carroll Co., Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner & Sons Baltimore, Md. north of Pa.				25a. REC'D BY REGISTRAR DATE JUN 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										#08514	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08524										CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Ellicott City					c. LENGTH OF STAY IN 1b MARYLAND						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 241 Montgomery Road					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Ellicott City						
3. NAME OF DECEASED (Type or print) Abbie					4. DATE OF DEATH Month June Day 22 Year 1966						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1874		9. AGE (in years last birthday) 91			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Howard County		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edmund Scott					14. MOTHER'S MAIDEN NAME Emily Gamble						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.					17. INFORMANT Address City Ralph Parlett 720 Crestleigh Rd. Ellicott	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2 wks. years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 9, 1966 , to June 24, 1966 , that (I) (we) last saw the deceased alive on June 20, 1966 , and that death occurred at 12:30 M, from the causes and on the date stated above.											
22a. SIGNATURE E. P. Williams					22b. DATE SIGNED 6/23/66						
22c. PHYSICIAN'S NAME (Type) E. P. WILLIAMS					22d. ADDRESS PROFESSIONAL ARTS Bldg BALTO 28						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town or county) (State) Ellicott City					
24. FUNERAL DIRECTOR Harry H. Witzke					25a. REC'D BY REGISTRAR DATE JUN 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08515

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 134 College Ave.		e. STREET ADDRESS 134 College Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle J. Last Upman		4. DATE OF DEATH Month June Day 5 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Upman		14. MOTHER'S MAIDEN NAME Anna Bezdold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW1	
17. INFORMANT JULIA UPMAN		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN DEATH AND EXAMINATION Instant 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George E. Burgtorf		22. DATE SIGNED 6-6-1966	
EXAMINER'S NAME (Type) George E. Burgtorf		Address Church Road Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/9/66	23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	23d. LOCATION (City, town or county) (State) BALTO. Md.
24. FUNERAL DIRECTOR F.S. MACNABB		25a. REC'D BY REGISTRAR JUN 7 1966	
ADDRESS 301 FREDERICK RD 21228		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

08215

08215

NAME	RELATIONSHIP	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DATE OF BURIAL	PLACE OF BURIAL
James E. Hunsford	husband	1914	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Anna E. Hunsford	wife	1914	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
George E. Hunsford	son	1940	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
John E. Hunsford	son	1945	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
William E. Hunsford	son	1950	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Robert E. Hunsford	son	1955	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Charles E. Hunsford	son	1960	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Edward E. Hunsford	son	1965	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Thomas E. Hunsford	son	1970	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Richard E. Hunsford	son	1975	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.
Donald E. Hunsford	son	1980	1980	Chicago, Ill.	Chicago, Ill.	Heart Disease	1980	Chicago, Ill.

6-1-1980

Chicago City

Chicago Road

George E. Hunsford

June 7 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08526

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08516

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Fayette</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. LENGTH OF STAY IN 1b <u>2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belle Vernon</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>44 B Pine Tree Road</u>				d. STREET ADDRESS <u>325 Water Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GENEVIEVE MARIE WALTERS</u>				4. DATE OF DEATH Month Day Year <u>June 29 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25 1912</u>	
9. AGE (in years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Burton</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Watten</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>170X</u>		17. INFORMANT <u>Mrs. John B. Walters</u> Address <u>Belle Vernon Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer of liver</u> <u>170X</u> DUE TO (b) <u>Carcinoma L. Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Adeno Carcinoma</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Obesity</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>66</u> to <u>6/29</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>6/29</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>J. M. Warren</u>				22b. DATE SIGNED <u>6/29/66</u>		22c. PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>	
22d. ADDRESS <u>Laurel</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 2, 1966</u>		23b. DATE THEREOF <u>July 2, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Belle Vernon</u>		23d. LOCATION (City, town or county) (State) <u>Belle Vernon Pa.</u>	
24. FUNERAL DIRECTOR <u>De Witt Danaedean Laurel Md.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				25c. DATE <u>JUL 7 1966</u>			

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08517

1. PLACE OF DEATH a. COUNTY HOWARD Baltimore, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage				c. LENGTH OF STAY IN 1b Baltimore - Rural Savage			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 304 Foundry Avenue				d. STREET ADDRESS 304 Foundry Avenue			
3. NAME OF DECEASED (Type or print) First EDWARD Middle C. Last WHEELER				4. DATE OF DEATH Month June Day 4 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-08		9. AGE (In years last birthday) yrs. 57	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator earth moving				10b. KIND OF BUSINESS OR INDUSTRY Savage Md		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME John N. Wheeler				14. MOTHER'S MAIDEN NAME Eva Cullum			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-16-6327		17. INFORMANT Nellie Wheeler Savage Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of head 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently shot self			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6 -4 19 66 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) (County) (State) Baltimore, Howard, Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.				22. DATE SIGNED 6/5/66			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-66		23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION (City or Town) (County) (State) Savage Howard Md.	
24. FUNERAL DIRECTOR De Witt Cavalier Laurel Md				25a. RECD BY REGISTRAR JUN 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Handwritten signature or text in the lower center of the page.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

08525

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08518

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harmon's Boarding Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS Rt. 3 Masser Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH DOYLE WRIGHT		4. DATE OF DEATH June 26, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1884
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) Pikesville, Md		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-5240	
17. INFORMANT Mrs. Ray T. Fitzwater, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic cardio vascular disease 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Thomas F. Herbert		22. DATE SIGNED 6-26-66	
EXAMINER'S NAME (Type) Thomas F. Herbert MD		23. NAME OF CEMETERY OR CREMATORY Lorraine	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-29-1966	
23c. NAME OF CEMETERY OR CREMATORY Baltimore, Md		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		25a. REC'D BY REGISTRAR JUN 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

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